



Geriatric Psychiatry Fellowship Application

Demographics

Date of application: _____ For training beginning in: _____

Full name:

Last First Middle

Present mailing address:

Street _____
City/State/Zip _____

Permanent mailing address:

Street _____
City/State/Zip _____

Phone: _____

Email: _____

Place of Birth: _____

Legally eligible to work in the USA? Yes ☐ No ☐

Visa status (if foreign national): _____

NRMP Participant Code: _____

Current PGY year (or already graduated): _____

Certification/Licensure/References

Certification

USMLE (MD applicants)

Step I: Passed? Yes ☐ No ☐ Date passed: _____ Score: _____
Step II: Passed? Yes ☐ No ☐ Date passed: _____ Score: _____
Step III: Passed? Yes ☐ No ☐ Date passed: _____ Score: _____

COMLEX (DO applicants)

Level I: Passed? Yes ☐ No ☐ Date passed: _____ Score: _____
Level II: Passed? Yes ☐ No ☐ Date passed: _____ Score: _____
Level III: Passed? Yes ☐ No ☐ Date passed: _____ Score: _____

ECFMG number (if applicable): _____ Date: _____ Not applicable ☐

Board-certified? Yes ☐ No ☐

If "yes" enter name of Board and year certified: _____

Licensure (primary)

State: _____ Number: _____ Type: _____
Original License date: _____ Expiration Date: _____

References

Please have at least three and no more than four letters of recommendation from professionals with whom you have worked and/or studied. One of these letters must be from your current or most recent Program Director. Have the letters sent directly to:

Azziza Bankole, M.D.
Geriatric Psychiatry Fellowship Director
2017 South Jefferson Street SW
Roanoke, VA 24014

Please list these references below:

Reference 1: _____
Reference 2: _____
Reference 3: _____
Reference 4: _____

Education

Undergraduate: (please provide full name and mailing address for all schools listed)

School 1:
Name: _____
Street: _____
City/State/Zip: _____
Dates attended: _____ to _____
Degree awarded: _____

School 2:
Name: _____
Street: _____
City/State/Zip: _____
Dates attended: _____ to _____
Degree awarded: _____

Graduate (medical, doctoral, or masters): (please provide full name and mailing address for all schools listed)

Institution 1:

Name: _____

Street: _____

City/State/Zip: _____

Dates attended: _____ to _____

Degree awarded: _____

Institution 2:

Name: _____

Street: _____

City/State/Zip: _____

Dates attended: _____ to _____

Degree awarded: _____

Are there further institutions? Yes ☐ No ☐ If yes, please provide information below.

Postgraduate: (please provide full name and mailing address for all schools listed)

Separate Internship: Yes ☐ No ☐ If yes, institution:

Name: _____

Street: _____

City/State/Zip: _____

Dates attended: _____ to _____

ACGME accredited: Yes ☐ No ☐

General Psychiatry Residency:

Name: _____

Street: _____

City/State/Zip: _____

Dates attended: _____ to _____

ACGME accredited: Yes ☐ No ☐

Fellowships:

Name: _____

Street: _____

City/State/Zip: _____

Dates attended: _____ to _____

ACGME accredited: Yes ☐ No ☐

Are there further fellowships: Yes ☐ No ☐ If yes, please provide information below.

Other professional training

Nature of training: _____

Institution: _____

Dates attended: _____ to _____

Other Experience

Relevant work experience:

Research experience and/or interests:

Publications/Presentations at scientific meetings:

Honors/Awards:

Professional memberships:

Outside interests/Achievements:

Personal Statement

Please describe your interest in geriatric psychiatry and plans for future professional work.
(1000-word limit)

I attest that the Attestation/Affidavit signed on a separate sheet applies to this application.

Signature

Date